MDR Tracking Number: M5-05-1177-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 12-16-04.

The IRO reviewed office visits, range of motion testing and report, mechanical traction, chiropractic manipulative treatment, simultaneous electrical stimulation/ultrasound, therapeutic exercises, group therapy, muscle testing, therapeutic activities, neuromuscular re-education, massage therapy and non-prescription drug rendered from 12-23-03 through 09-17-04 that were denied based upon "V".

The IRO determined that therapeutic exercises during the period of 12-23-03 through 07-23-04 **were** medically necessary. The IRO determined that all other treatments, services, procedures, office visits, drugs and examinations in dispute during the period of 12-23-03 through 09-17-04 **were not** medically necessary. The amount of reimbursement due from the carrier for the medical necessity issues equals **$325.00.**

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the **majority** of issues of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 01-19-05, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

CPT code 99070 dates of service 12-17-03 (consumable TENS supplies DME #5 or DME #6-$25.00 and Biofreeze DME #28-$8.00), 01-29-04 (Positex personal wedge DME #30=$87.00), 03-30-04 (consumable TENS supplies DME #5 or #6-$25.00), 05-20-04 (Biofreeze DME #28-$8.00) and date of service 05-25-04 (consumable TENS supplies DME #5 or #6-$25.00) denied with denial code

"G/B377" (this is a bundled procedure; no separate payment allowed). The carrier has made no payment. Per Rule 133.304(c) and 134.202(a)(4) the carrier did not specify which code 99070 was global to. Reimbursement is recommended in the amount of **$145.00 ($25.00+$8.00+$87.00+$25.00+$8.00+$25.00).**

CPT code 99080-73 date of service 08-09-04 denied with denial code "V/X435" (based on peer review, further treatment is not recommended). Per Rule 129.5 the TWCC-73 is a required report and is not subject to an IRO review. Reimbursement is recommended in the amount of **$15.00.**

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees totaling **$485.00** in accordance with the Medicare program reimbursement methodologies effective August 1, 2003 per Commission Rule 134.202(c), plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Decision is applicable for dates of service 12-17-03, 01-29-04, 03-30-04, 05-20-04, 05-25-04, 07-16-04, 07-19-04, 07-21-04 and 07-23-04 in this dispute.

This Findings and Decision and Order are hereby issued this 22nd day of April 2005.

Medical Dispute Resolution Officer
Medical Review Division

Enclosure: IRO Decision

April 18, 2005
February 14, 2005

Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

REVISED REPORT
"Therapeutic activities" removed from disputed services.

Re: Medical Dispute Resolution
MDR #: M5-05-1177-01
TWCC#:
Injured Employee:
DOI:
SS#:
IRO Certificate No.: IRO 5055

Dear Ms. ___:

IRI has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, IRI reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of Independent Review, Inc. and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is licensed in chiropractic, and is currently on the TWCC Approved Doctor List.

Sincerely,

Gilbert Prud'homme
Secretary & General Counsel

GP:thh

REVISED 04/18/05
REVIEWER'S REPORT
M5-05-1177-01

Information Provided for Review:
TWCC-60, Table of Disputed Services, EOB's
Information provided by Requestor:
- Correspondence
- Office visits 11/05/03 – 09/30/04
- Daily progress notes 11/11/03 – 12/10/04
- Therapeutic procedures 01/07/04 – 09/28/04
- Range of motion tests 06/11/04 – 09/30/04
- Radiology reports 11/12/03 – 03/15/04

Information provided by Orthopedic Surgeon:
- Office visits 11/17/03 – 12/09/04

Information provided by Pain Management Specialist:
- Office visits 11/05/03 – 01/07/04

Information provided by Respondent:
- Correspondence
- Designated doctor reviews

Clinical History:
This male patient underwent physical medicine treatments after an on-the-job injury on ___. Subsequently, the patient underwent rehabilitation therapy after hip surgery on 04/30/04.

Disputed Services:
Office visits, range of motion testing & report, mechanical traction, chiropractic manipulative treatment, simultaneous electrical stimulation/ultrasound, therapeutic exercises, group therapy, muscle testing, neuromuscular re-education, massage therapy, non-prescription drug during the period of 12/23/03 thru 09/17/04.

Decision:
The reviewer partially disagrees with the determination of the insurance carrier and is of the opinion that all therapeutic exercises (97110) in dispute during the period of 12/23/03 through 07/23/04 were medically necessary. All other treatments, services, procedures, office visits, drugs and examinations in dispute during the period of 12/23/03 through 09/17/04 were not medically necessary in this case.

Rationale:
Physical medicine is an accepted part of a rehabilitation program following surgery. Therefore, the therapeutic exercises (97110) through 07/23/04 were medically necessary and indicated.

However, there was insufficient documentation to support the medical necessity for any of the other disputed treatments, procedures, office visits or examinations.

The *Guidelines for Chiropractic Quality Assurance and Practice Parameters*[1] Chapter 8 under "Failure to Meet Treatment/Care Objectives" states, "After a maximum of two trial therapy series of manual procedures lasting up to two weeks each (four weeks total) without significant documented improvement, manual procedures may no longer be appropriate and alternative care should be considered." Therefore, since the patient had not received any significant benefit during that time frame (although no re-examinations were performed, pain ratings remained unchanged), there was no support for continuing the same unsuccessful treatment.

In regard to the neuromuscular re-education services (97112), there was nothing in either the diagnosis or the physical examination findings on this patient that demonstrated the type of neuropathology that would necessitate the application of this service. According to a Medicare Medical Policy Bulletin[2], "This therapeutic procedure is provided to improve balance, coordination, kinesthetic sense, posture, motor skill, and proprioception. Neuromuscular reeducation may be reasonable and necessary for impairments that affect the body's neuromuscular system (e.g., poor static or dynamic sitting/standing balance, loss of gross and fine motor coordination, hypo/hypertonicity). The documentation in the medical records must clearly identify the need for these treatments." In this case, the documentation failed to fulfill these requirements, rendering the performance of this service medically unnecessary.

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[1] Haldeman, S; Chapman-Smith, D; Petersen, D *Guidelines for Chiropractic Quality Assurance and Practice Parameters,* Aspen Publishers, Inc.
[2] HGSA Medicare Medical Policy Bulletin, Physical Therapy Rehabilitation Services, original policy effective date 04/01/1993 (Y-1B)

Therapeutic exercises may be performed in a clinic one-on-one, in a clinic in a group, at a gym or at home with the least costly of these options being a home program. A home exercise program is also preferable because the patient can perform them on a daily basis. On the most basic level, the provider has failed to establish why the services were required to be performed one-on-one when current medical literature states, "…there is no strong evidence for the effectiveness of supervised training as compared to home exercises."[3] Furthermore, even if the extensive one-on-one therapy had been medically necessary, it would not have been needed for the duration of time in this case and any gains would have likely also occurred through home exercises.

The records also failed to substantiate the medical necessity of continuing the post-surgical services after 07/19/04. Those treatments did not fulfill statutory requirements[4] since the patient obtained no relief, promotion of recovery was not accomplished and there was no enhancement of the employee's ability to return to work.

Specifically, in addition to the fact that the patient had not returned to employment, his pain ratings were still at 6/10 on date of service 07/19/04. Moreover, from 06/11/04 to 09/30/04, the claimant's right hip extension, right hip internal rotation and lumbar spine flexion ranges of motion had actually decreased.

[3] Ostelo RW, de Vet HC, Waddell G, Kerchhoffs MR, Leffers P, van Tulder M, Rehabilitation following first-time lumbar disc surgery: a systematic review within the framework of the cochrane collaboration. Spine. 2003 Feb 1;28(3):209-18.
[4] Texas Labor Code 408.021